

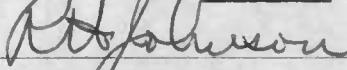
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 13083

FOR STATE  
HEALTH DEPT.

13095

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1		MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
M		13083									
1. PLACE OF DEATH a. COUNTY		SOMERSET MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		SOMERSET b. C. MARYLAND			
		c. LENGTH OF STAY IN lb PRINCESS ANNE 68 YEARS						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X PRINCESS ANNE			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)						d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First MILDRED		Middle BEAUCHAMP		Last ADAMS		4. DATE OF DEATH NOV. 6		Month Year 1961	
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH AUG. 31, 1893		9. AGE (In years including birthday) 68 yrs.		IF UNDER 14 YRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME OLIVER T. BEAUCHAMP		14. MOTHER'S MAIDEN NAME IDA DAVIS									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT MR. M.H. ADAMS		Address PRINCESS ANNE, MD.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH Sudden									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Acute Coronary Occlusion									
420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO Hypertension									
(b)		DUE TO years (8 yrs)									
(c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour o. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		DATE SIGNED 11/7/61									
ACTUAL SIGNATURE 		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>									
EXAMINER'S NAME (Type)		R. H. Johnson, M.D.									
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11-8-1961		22c. NAME OF CEMETERY OR CREMATORIUM MANOKIN PRESBYTERIAN		22d. LOCATION (City, town, or county) PRINCESS ANNE, MD.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE 		ADDRESS PRINCESS ANNE, MD.		24a. REC'D BY REGISTRAR NOV 13 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		DATE			

MISSOURI STATE DEPARTMENT OF HEALTH - DIVISION OF  
MEDICAL SURVEILLANCE CERTIFICATE OF DEATH

STATE BOB  
120 UNIT 5

0

DEATH

1

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
**may be signed by the hospital or attending physician**

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

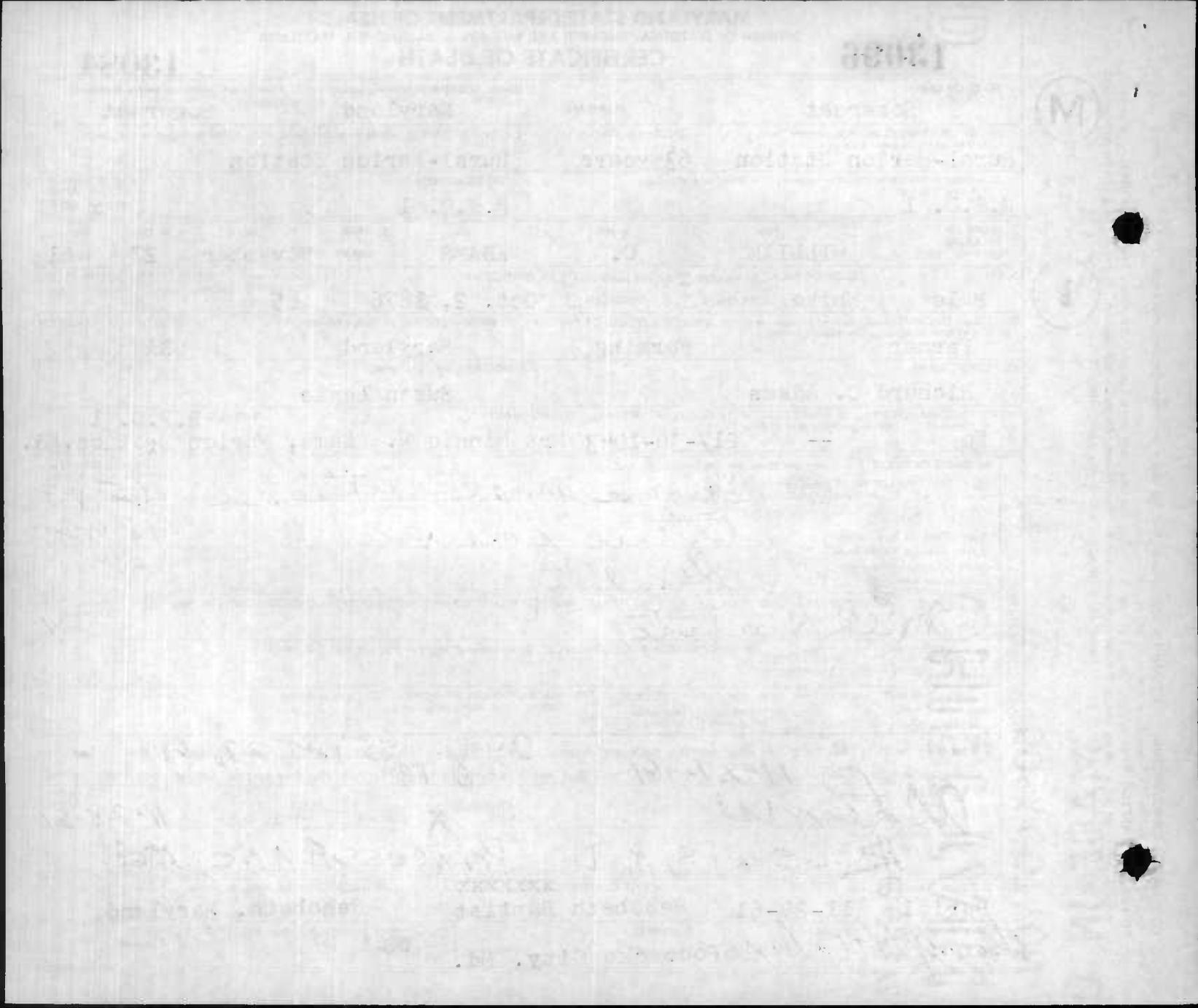
**MARYLAND STATE DEPARTMENT OF HEALTH**  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

**13096**

**CERTIFICATE OF DEATH**

**13084**

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Marion Station</b>		c. LENGTH OF STAY IN 1b <b>63 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>R.F.D. 1</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>WILLIAM</b>	Middle <b>C.</b>	Last <b>ADAMS</b>
4. DATE OF DEATH	Month <b>November</b>	Day <b>27</b>	Year <b>1961</b>
S. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 2, 1876</b>
9. AGE (In years last birthday) <b>85 yrs.</b>	10. IF UNDER 1 YEAR Months <b>85</b> Days <b>0</b>	11. IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Richard C. Adams</b>		14. MOTHER'S MAIDEN NAME <b>Susan Beale</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-36-1043</b>	
17. INFORMANT		Address <b>R.F.D. 1</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Arterio-sclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>15 yrs.</b>	
(b) DUE TO Cerebral arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH <b>15 yrs.</b>	
(c) DUE TO Senility			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Medi diabatic</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Aug. 19, 1955</b> to <b>Nov. 27, 1961</b> , that (I) (we) last saw the deceased alive on <b>11-27-1961</b> , and that death occurred at <b>1 A.M.</b> from the causes and on the date stated above.		22b. DATE SIGNED <b>11-28-61</b>	
22a. SIGNATURE <b>A.C. Lewis</b>		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. ADDRESS <b>Princess Anne, Md.</b>
22c. PHYSICIAN'S NAME (Type) <b>A.C. Lewis, M.D.</b>		23d. LOCATION (City, town, or county) (State) <b>Rehobeth, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11-29-61</b>	
23c. NAME OF CEMETERY <b>ALEXANDRIA Rehobeth Baptist</b>		23d. LOCATION (City, town, or county) (State) <b>Rehobeth, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Henry J. Watson</b>		ADDRESS <b>Pocomoke City, Md.</b>	
25a. REC'D BY REGISTRAR <b>DEC 1 1961</b>		25b. REGISTRAR'S SIGNATURE <b>Henry J. Watson</b>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13097

## CERTIFICATE OF DEATH

Reg. Deth No. 13085

M

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Somerset</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Md.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Marion Station</u>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Marion Station X</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>First Isaac Thomas Dennis</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>26</u> Year <u>1961</u>	
5. SEX <u>Male</u> 6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 2-1891</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seafood Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Marion Sta., Som. Co.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Frank Dennis</u>	
14. MOTHER'S MAIDEN NAME <u>Ella Merril</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>	
16. SOCIAL SECURITY NO. <u>212-12-34254</u>		17. INFORMANT <u>Mrs. Anna Sterling - Marion Sta., Md.</u>	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute dil. of heart-</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic myositis - C. dat. nephritis -</u> (c) <u>(with metastasis in liver)</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Carcinoma of prostate + bladder -</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Oct. 30</u> , 19 <u>61</u> , to <u>Nov. 27</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>Nov. 27</u> , 19 <u>61</u> , and that death occurred at <u>20</u> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>MARION STA - MARYLAND</u> DATE SIGNED <u>11-28-61</u>	
ACTUAL SIGNATURE <u>George G. Coulter</u>		M.D.	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 29, 1961</u>	22c. NAME OF CEMETERY <u>Family Cemetery</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles H. Ward - Marion Sta., Md.</u>		ADDRESS	22d. LOCATION (City, town, or county) <u>Marion Sta., Md., Som. Co.</u> (State)
		24a. REC'D BY REGISTRAR <u>DEC 1 '61</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

Wetland Ecosystem

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

**13098**

**13086**

**CERTIFICATE OF DEATH**

1. PLACE OF DEATH a. COUNTY <b>SOMERSET</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>SOMERSET</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CRISFIELD</b>		c. LENGTH OF STAY IN lb <b>2 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CRISFIELD</b>		d. STREET ADDRESS <b>103 MAIN STREET</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>E.W. MCCREADY MEMO HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>BIRDIE</b>		First <b>M.</b>	Middle <b>MARSHALL</b>	Last <b>NOVEMBER 3</b>	Month <b>1961</b>	Day	Year
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>SEPT 9, 1894</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>VIRGINIA</b>		9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. <b>67 yrs.</b> Months Deys Hours Min.	
13. FATHER'S NAME <b>TONY MIDDLETON</b>		14. MOTHER'S MAIDEN NAME <b>LILLIAN RUSSELL</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		Address	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank or dates of service) <b>NO</b> <b>None</b>		16. SOCIAL SECURITY NO. <b>212-10-4699A</b>		17. INFORMANT <b>LILLIAN HOLLAND CRISFIELD, MD.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>260X</b>		DUE TO <b>Coronary Thrombosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Arteriosclerosis - Hypertension</b>		DUE TO <b>Diabetes mellitus</b>		Years <b>3 yrs -</b>		PART III. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. 20d. INJURY OCCURRED p.m. 19 While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>?</b> to <b>Nov. 3, 1961</b> , that (I) (we) last saw the deceased alive on <b>Nov. 3, 1961</b> , and that death occurred at <b>11 AM</b> from the causes and on the date stated above.		22e. SIGNATURE <b>Sarah M. Peyton</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>11-4-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>SARAH M PEYTON, M.D.</b>		23d. LOCATION (City, town or county) <b>Crisfield, Maryland</b>		23e. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Nov. 5, 1961</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Bradshaw &amp; Sons, Crisfield, Maryland</b>		ADDRESS		23c. NAME OF CEMETERY OR CREMATORIAL <b>Crisfield Cemetery</b>		23d. LOCATION (City, town or county) <b>Crisfield, Maryland</b>	
VR A15 (4) 1SM 7/61				25a. REC'D BY REGISTRAR DATE <b>NOV 10 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

RECEIVED  
MAY 10 1968  
FBI - NEW YORK



SEARCHED

SEARCHED

212-26900

INDEXED

INDEXED

MAILED WITH FILE

MAILED WITH FILE

SEARCHED

SEARCHED

SEARCHED

55-14691-Sub A

SEARCHED

SEARCHED

SEARCHED - INDEXED

SEARCHED - INDEXED

SEARCHED - INDEXED

SEARCHED - INDEXED - SERIALIZED - FILED - APR 10 1968 - 200 - OK

30 VOL 10  
10 VOL

SEARCHED - INDEXED - SERIALIZED - FILED - APR 10 1968

SEARCHED - INDEXED - SERIALIZED - FILED - APR 10 1968

SEARCHED - INDEXED - SERIALIZED - FILED - APR 10 1968

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4

may be signed by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Film G302 12/13/61 iwk

13099

## CERTIFICATE OF DEATH

Reg. Dist. No. 13087

1. PLACE OF DEATH a. COUNTY <b>Somerset</b>		MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>SOMERSET</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CRISPIN L.D.</b>		c. LENGTH OF STAY IN 1b <b>3 DAYS</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FAIRMOUNT</b>		d. STREET ADDRESS <b>1</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Daisey Nursing Home</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print)	First <b>IDA</b>	Middle <b>E.</b>	Last <b>MOWBRAY</b>	4. DATE OF DEATH Month <b>NOV.</b> Day <b>50</b> Year <b>1961</b>		
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>JUNE 19, 1876</b>	9. AGE (In years last birthday) yrs. <b>85</b>	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>FAIRMOUNT</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>GEORGE RICHARDS</b>			14. MOTHER'S MAIDEN NAME <b>MARY RICHARDS</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <b>MRS BLANCH FORD</b>	Address <b>FAIRMOUNT, MD.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Dil. of heart</b> INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>						
592X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Bronchitis - Bronchectasis</b> years (c) <b>C. Lat. Nephritis - C. Myocarditis</b> years						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>General Arteriosclerosis</b> years -						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Marion</b>	(County) <b>MD.</b>	(State) <b>MARYLAND</b>
21. I certify that I attended the deceased from <b>Nov 28, 1961</b> , to <b>Nov 30, 1961</b> , that I last saw the deceased alive on <b>Nov 30, 1961</b> , and that death occurred at <b>104 M</b> , from the causes and on the date stated above.						
ACTUAL SIGNATURE <b>George C Coulbourn M.D.</b> ADDRESS (Street, city or town, state) <b>Marion, MD.</b> DATE SIGNED <b>12/1/61</b>						
PHYSICIAN'S NAME (Type) <b>George C. COULBOURN MARION STA. MARYLAND</b>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>12-2-1961</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>FAIRMOUNT CEMETERY</b>	22d. LOCATION (City, town, or county) <b>FAIRMOUNT, MD.</b>	(State) <b>MARYLAND</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lewis R. Wilson</b>		ADDRESS <b>PRINCESS ANNE, MD.</b>	24a. REC'D BY REGISTRAR <b>DEC 4 '61</b>	24b. REGISTRAR'S SIGNATURE <b>Charles E. Hearn</b>		

WYOMING STATE DEPARTMENT OF HEALTH - SWIMMING

CERTIFICATE OF DEATH

NAME

NAME

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

**CERTIFICATE OF DEATH**

13100

13088

1. PLACE OF DEATH a. COUNTY <b>Somerset</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b>		c. LENGTH OF STAY IN lb <b>50 years</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Somerset</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>39 Crisfield</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>9 W. Main Street</b>		d. STREET ADDRESS <b>9 W. Main Street</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First <b>MAMIE</b>	Middle <b>ELIZABETH</b>	Last <b>PUSEY</b>	4. DATE OF DEATH <b>November 21 1961</b>	Month <b>November</b>	Day <b>21</b>	Year <b>1961</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>
S. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>Aug. 31, 1891</b>	9. AGE (In years last birthday) <b>70 yrs.</b>						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
13. FATHER'S NAME <b>Thomas Cox</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Poleyette</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>J. Bennett Fusey, 9 W. Main, Crisfield, Md.</b>		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic nephritis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Diabetes Mellitus</b> DUE TO (c) _____											
INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs -</b> <b>15 yrs -</b>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Crisfield, Md.</b>		(County) <b>Crisfield, Md.</b>		(State) <b>Md.</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>Aug. 31 1961</b> to <b>Nov. 21 1961</b> , that (I) (we) last saw the deceased alive on <b>Nov. 21 1961</b> , and that death occurred at <b>10 AM</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>Sarah M. Peyton</b>		M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>Nov. 25 1961</b>							
22c. PHYSICIAN'S NAME (Type) <b>Sarah M. Peyton</b>		22d. ADDRESS <b>33 W. Main St., Crisfield, Md.</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Nov. 24, 1961</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Sunnyridge Cemetery</b>		23d. LOCATION (City, town, or county) <b>Crisfield, Md.</b>		(State) <b>Md.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Bradshaw &amp; Sons, Crisfield, Md.</b>		ADDRESS		25a. REC'D BY REGISTRAR <b>NOV 29 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Charles S. Krause</b>					

MSI



an option down

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

13089

1. PLACE OF DEATH a. COUNTY <b>Somerset</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Somerset</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Princess Anne</b>		c. LENGTH OF STAY IN 1b <b>66 Years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Princess Anne</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Jannie</b>	Middle <b>C.</b>	Last <b>Smith</b>	4. DATE OF DEATH	Month <b>II</b>	Day <b>13</b>	Year <b>1961</b>
5. SEX	6. COLOR OR RACE <b>Female</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-24-1895</b>	9. AGE (In years last birthday) <b>66</b> yrs.	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS Days <b>0</b>	Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cook</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hotel</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph Morris</b>		14. MOTHER'S MAIDEN NAME <b>Susie Dennis</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Sidney Smith, Princess Anne, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic myocarditis</b> DUE TO <b>443-X</b>						INTERVAL BETWEEN ONSET AND DEATH <b>3 years</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <b>Hypertension</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m.      p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> At work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Princess Anne</b>		20f. (City or town) (County) (State) <b>Princess Anne, Maryland</b>	
21. I certify that I attended the deceased from <b>April 10th, 1960</b> to <b>Nov 12th, 1961</b> , that I last saw the deceased alive on <b>Nov 12th, 1961</b> , and that death occurred at <b>1:30A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Princess Anne, Maryland</b>							
DATE SIGNED <b>April 10th, 1960</b>							
ACTUAL SIGNATURE <b>Eldon G. Johnson, M.D.</b>							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>II/15/61</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>John Wesley</b>		22d. LOCATION (City, town, or county) <b>Princess Anne, Maryland</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William H. James Jr. Princess Anne, Md</b>		ADDRESS		24a. REC'D BY REGISTRAR DATE <b>NOV 15 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Krause</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 7 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEPARTMENT OF DEFENSE - MILITARY-STATE QUALITY  
CERTIFICATE OF DEATH

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 13000

1. PLACE OF DEATH a. COUNTY <b>Somerset</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Somerset</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Manokin</b>		c. LENGTH OF STAY IN 1b <b>Life Time</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Manokin</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <b>James</b>	Middle <b>Edward</b>	Last <b>Waters</b>	4. DATE OF DEATH Month <b>II</b>	Day <b>24</b>	Year <b>1961</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>II/7/1877</b>		9. AGE (In years last birthday) yrs. <b>82</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Labor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Moses Waters</b>		14. MOTHER'S MAIDEN NAME <b>Charlotte Smith</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>213-18-5827</b>		17. INFORMANT <b>Pauline Waters, Manokin, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  59 <b>X</b> DUE TO <b>Coronary Thrombosis</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <b>Hypertensive Cardiovascular Disease</b> 5 yrs (c) DUE TO <b>Chronic Renal Disease</b> 7 yrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Princess Anne</b>	(County) <b>Md.</b> (State)
21. I certify that I attended the deceased from <b>Sept 10</b> , 1960, to <b>Nov 24</b> , 1961, that I last saw the deceased alive on <b>Nov 24</b> , 1961, and that death occurred at <b>6:30 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>B. Frank Giganti</b>	ADDRESS (Street, city or town, state) <b>PRINCESS ANNE Md.</b>						DATE SIGNED <b>11-26-61</b>
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>II/29/61</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Charles Wesley, Methodist, Manokin Md</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William H. James Jr. Princess Anne, Md</b>				ADDRESS		24a. REC'D BY REGISTRAR <b>DEC 1 '61</b>	
						24b. REGISTRAR'S SIGNATURE <b>Arthur L. Thrasher</b>	

CERTIFICATE OF DEATH

DEATH

T